

# EXHIBIT G



Paul G. Auwaerter, M.D.

*Infectious Diseases Consultant*

**Conor Lamb, Esquire**

Kline & Specter, PC  
1525 Locust Street  
Philadelphia, Pennsylvania 19102

24 April 2024

*Re: Stacey Wolking*

Dear Mr. Lamb:

Upon your request, I have reviewed the records relative to the above-captioned matter and submit this report to express my opinions from an infectious disease perspective. My fees are \$600/hour for reviewing records, making conference calls, and generating expert reports. I have been paid \$5148 to date,

I am a board-certified physician in infectious disease at the Johns Hopkins Hospital and Health System. I serve as the Clinical Director of the Division of Infectious Diseases, Department of Medicine, at Johns Hopkins University School of Medicine and hold an endowed chair, the Sherrilyn and Ken Fisher Professor of Medicine. I am also the chief medical officer at the Point of Care Information Technology Center at Johns Hopkins University School of Medicine and the editor-in-chief of the Johns Hopkins Antibiotic Guide. I received my undergraduate *A.B.* degree in biology from Columbia University in New York. I also obtained my medical degree from the College of Physicians and Surgeons, Columbia University. My internal medicine residency training was accomplished at Johns Hopkins Hospital, and infectious diseases fellowship through the Johns Hopkins University School of Medicine in Baltimore, Maryland. I have attached my *curriculum vitae*, which I have incorporated herein. It contains additional information and details regarding my educational background, training, experience, affiliations, and publications.

I routinely evaluate patients with tickborne disease and chronic syndromic illnesses. I served as an author of the *Infectious Diseases Society of America 2020 Guideline on the Diagnosis and Management of Babesiosis*. This guideline outlines the essentials to facilitate clinical decisions for diagnosing and treating the tickborne parasite babesia. The guideline



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is based on a rigorous review of the best available scientific evidence and is meant to improve patient outcomes.

I focused my review on the care rendered to Stacey Wolking when she was under the treatment of Dr. Henry Lindner from 2013 to 2022. My review and opinions are based on the following documents and information related to Ms. Wolking's care, provided to me by your office

1. Medical Records:
  - a. Henry Lindner, MD (Lindner Chart 1-607.pdf)
  - b. Images of pill bottles
  - c. Pharmacy records
  - d. Encompass Rehabilitation
  - e. Loudoun Hospital (INOVA)
2. Henry H. Lindner's "About Me"
3. PowerPoint slide decks by Dr. Lindner
4. Medical Literature provided by Dr. Lindner
5. Case reports by Dr. Lindner
6. *Treatment of Chronic Babesiosis* authored by Dr. Linder and given to Ms. Wolking
7. Deposition of Courtney Young
8. Deposition of Brian Bryk
9. Deposition of Henry Lindner

### **Brief Summary:**

Stacey Wolking was under the care of Dr. Henry Lindner first in 2013 for complaints of hot flashes, sweats and "cortisol deficiency." The focus of recommendations and treatments was on hormone replacement therapy, including pharmacy compounded products. This strategy was employed for subsequent years.

Office notes from June 30, 2020, and September 29, 2020 notes her symptoms as including getting more upset with stress, hair loss, extreme fatigue, migraines, heart pounding, insomnia, headaches, excessive sweating, general achiness and stiffness. These symptoms were diagnosed as a symptomatic menopausal state and treated with prescriptions of progesterone, testosterone, estradiol and also DHEA.

Her subsequent encounter on June 25, 2021, notes marked fatigue, nausea, abdominal discomfort, marked stiffness/achiness, weight gain, brain fog, constant headache, tinnitus, flushing, excessive sweating, leg vibrations, left ankle/foot swelling (since Sept '20) and urinary incontinence, although sleep was better. Treatment with hormones continues; however, Dr. Lindner notes a history of tick bites thirteen years earlier in 2008, treated with antimicrobials with improvement in

2018, but without resolution and worsening over the last three years. He suspects infection with *Babesia odocoilei*. Atovaquone 750 mg/5mL suspension is prescribed twice daily # 210, RF x 1 called into Harris (Teeter) and testing at IGeneX is recommended.

An email from Dr. Lindner to Ms. Wolking (8/6/21) states that she clearly has a babesial infection. On 8/17/21, he ordered tafenoquine 150 mg #4 for a single dose. On 10/4/21, Dr. Lindner ordered azithromycin. A note from 1/17/22 states her symptoms are most certainly due to *B. odocoilei* and that she is "herxing" in response to atovaquone, azithromycin and tafenoquine. She is also prescribed ivermectin and is noted to have skin findings consistent with Bartonella. During her May 13, 2022, phone call, she notes increased fatigue, brain fog, shortness of breath, dark urine, headache, tinnitus, liver and armpit pain, itchy legs, itch feelings, and trouble sleeping. Dosings of hydrocortisone to treat the inflammation of dying babesia are changed to prednisone along with Arte-M (for babesia) and rifabutin for Babesia and Bartonella. The initial prednisone dosing (based on his daughter's schedule) is 15.75 mg per day divided into 12 variable dosings, and she is also given a schedule for 59.25 mg spread out over 12 dosings per day. Ms. Wolking's email of 5/21/22 indicates she took 88 mg on a Thursday and felt horrible most of the day. June 2022 emails indicate she has taken prednisone in the 40 mg range.

She continued taking prednisone in August, including 8/13/22 notes that she had just taken 190 mg of prednisone that day. On 8/21/22, Stacy's husband, Daryl, wrote Dr. Lindner to state that she feels like she is dying, "laying here wasting away." High dosings of dexamethasone were taken, e.g., Sunday equaled 148 mg of prednisone-equivalent divided over 11 doses that day. During September, corticosteroid dosing continued, including prednisone and hydrocortisone combinations, as Dr. Lindner recommended. On 9/25/22, Ms. Wolking reported taking 775 mg yesterday. Dr. Lindner's deposition states that dosings were as high as 1526 mg prednisone equivalents [9/29/22] and 1848 mg dose equivalents [10/3/22] to control "herxing."

In October, Ms. Wolking presented to the hospital with one week of abdominal pain. In the OR on 10/8/22, she was found to have a pneumoperitoneum, which required surgical resection of small bowel perforation, requiring an ostomy. Blood cultures revealed polymicrobial bacteremia.

Prescriptions by Dr. Lindner and filled for corticosteroids include:

Tunkhannock Compounding Center

8/8/22:	Prednisone 10 mg #500
8/16/22:	Dexamethasone 4 mg #200
9/27/22:	Dexamethasone 4 mg #100 (#300 original Rx)
10/4/22:	Dexamethasone 4mg #200

## Other pharmacies

8/7/22:	Prednisone 5 mg #120
8/13/22:	Dexamethaxone 4 mg #120
8/30/22:	Prednisone 1 mg # 180
9/26/22:	Dexamethasone 4 mg #120
10/5/22:	Dexamethasone 4 mg #30

**Opinions:**

Stacy Wolking suffered from long-standing symptoms of fatigue, hot flashes and sweats that were judged to worsen in 2021 to include other symptoms, including brain fog, headaches and weight gain. These nonspecific complaints prompted Dr. Lindner to diagnose clinically, without laboratory confirmation or compatible clinical symptoms, a chronic *Babesia* infection with a hitherto unrecognized agent of human disease, *Babesia odocoilei*. She was prescribed a variety of antimicrobial agents that failed to improve her condition substantially, and Dr. Lindner then added corticosteroid therapy to staunch suspected inflammation from what he believed to be organism die-off. Dr. Lindner's treatment of Ms. Wolking in August through October 2022 witnessed massive doses of corticosteroids (prednisone and dexamethasone).

Based on her nonspecific clinical symptoms and laboratory testing, Ms. Wolking had no evidence of babesial infection to account for her symptoms. Babesial infection can be subclinical or cause fever and chills, which were not mentioned during her care. Moreover, significant infection causes hemolytic anemia, often accompanied by abnormalities in white blood cells, platelet counts, and liver function tests—none of which she had as evidence to support the diagnosis before starting therapy. Even so, if Ms. Wolking had symptomatic babesial infection, treatment in non-immunocompromised patients is 7 to 10 days of antimicrobial therapy with atovaquone plus azithromycin as the first line—not the polypharmacy and long-term therapy employed by Dr. Lindner.

Specifically, persistent babesial infection strikes immunosuppressed patients, which was not a condition Ms. Wolking suffered in 2021. Moreover, the organism implicated, *Babesia odocoilei*, is a tick-transmitted infection of deer and had not been previously reported in humans. Given its wide prevalence in deer populations, it is notable that it has not caused human disease, which is typical of many babesia species that remain oriented to a specific animal host. Besides a report by Scott 2021 [Diagn 2021 Jun 11(6):947] of two possible patients (including the first author) with this organism, no other laboratory has corroborated this finding.

Her symptoms fell into a syndromic complex, exacerbated by the side effects of prescribed antimicrobials, including atovaquone, azithromycin, artemether, rifabutin and tafenoquine. Dr. Lindner then added the corticosteroid dosings starting in May

2022 but increasing to extraordinarily high levels in August, September and October. It is my opinion, to a reasonable degree of medical certainty, that these steroids caused her bowel perforation. Dr. Lindner's approach of using nonspecific symptoms without supporting laboratory evidence via email and phone consultations to diagnose a chronic, novel infection falls substantially far from reasonable medical care.

While Ms. Wolking had no infectious illness, hypothetically, if she were suffering from babesiosis, corticosteroids are contraindicated as they suppress the immune system and make infection more difficult to eradicate or worsen the illness. They have no role in the primary treatment of acute or persistent babesiosis. As an example, Micromedex®, a standard reference tool used by clinicians, including pharmacists, lists six drugs with evidence of efficacy for babesiosis: atovaquone, azithromycin, clindamycin hydrochloride, clindamycin palmitate hydrochloride, clindamycin phosphate and quinine sulfate. There is no mention of corticosteroid therapy. As a general principle that is common knowledge among medical students, clinicians, nurses and pharmacists, corticosteroids at high and prolonged doses are not used to treat any infection, whether it be bacterial, fungal, viral or parasitic.

In summary, Ms. Wolking suffered iatrogenic complications brought on by Dr. Lindner treating a factitious illness and prescribing outrageous quantities of prednisone and dexamethasone. While Dr. Lindner prescribed long-term and various antimicrobials that were without merit, they may have contributed to some of her somatic symptoms but did not directly lead to severe consequences leading to her hospitalization.

I hold these opinions to a reasonable degree of medical certainty. Should any additional records or information become available, I reserve the right to update my opinions.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Paul G. Auwaerter", written over a light blue horizontal line.

Paul G. Auwaerter, M.D.